

Provider Insider

Alabama Medicaid Bulletin

July 2001

The checkwrite schedule is as follows:

07/06/01 07/20/01 08/03/01 08/17/01 09/07/01 09/14/01

As always, the release of direct deposits and checks depends on the availability of funds.

External Breast Prostheses are Covered by Medicaid

Effective June 1, 2001, external breast prostheses following mastectomy for breast cancer are covered for all Medicaid eligible recipients meeting established medical criteria. Coverage is available for either approved external prostheses or breast reconstruction (please refer to Provider Notice 00-04) when coverage criteria are met.

Coverage is available for the external breast prostheses when all of the following criteria are met:

- a) Recipient must be eligible for Medicaid on the date of service for provision of prostheses.
- b) The date of the mastectomy and the ICD 9-diagnosis code for which performed (174.0-174.9, 198.81, 233.0) is provided in the Clinical Statement section of the Alabama Prior Review and Authorization Request Form 342.
- c) The appropriate procedure codes are billed as indicated in the box to the right:

PC	Description	Limits
L8000	Breast prosthesis, mastectomy bra	6/Year
L8015	External breast prosthesis garment, with mastectomy form	2/Year
L8020	Breast prosthesis, mastectomy form	2/Year
L8030	Breast prosthesis, silicone or equal	2/Year
L8035*	Custom breast prosthesis, post mastectomy, molded to patient model	
L8039*	Breast prosthesis, not otherwise classified Evaluated on a case-by-case basis with submission of pricing information and medical documentation	

*These codes will be reviewed on a case-by-case basis. Additional documentation may be requested to determine medical necessity for coverage.

NOTE: All required documentation must be attached to completed Form 342, submitted to EDS and approval obtained prior to providing prosthetic devices. Once breast reconstruction has been performed external breast prostheses are non-covered.

Limitations

Maximum calendar year limits apply to each of the procedures as indicated above.

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Pass It On!

Everyone needs to know the latest about Medicaid.

Be sure to route this to:

- ☐ Office Manager
- ☐ Billing Dept.
- ☐ Medical/Clinical Professionals
- ☐ Other _____

Dental Providers Must Submit "Completed" Claims

Claims for services provided should be submitted upon completion. This policy applies to all dental procedure codes covered by Medicaid. The word "completed" means different things depending on the applicable procedure. Some common examples are crowns, post and cores, and space maintainers for which completed means insertion in the mouth and final cementation accomplished. For root canals, it means final obturation has been completed. For scaling and root planing, it means the entire quadrant has been scaled and root planed.

Targeted Case Management services are available in most of the state to increase patient compliance. If you would like more information on this service or others available to you, contact the Medicaid Dental Program at 334-242-5997.

Intensive Developmental Diagnostic Assessment Covered by Medicaid

Medicaid will pay for a comprehensive multidisciplinary developmental screening assessment through the EPSDT program, when preformed by a Medicaid approved provider. Please note the procedure codes used for billing these tests were changed effective 1-1-01. The procedure codes have been changed to 96110 (normal findings) and 96111 (abnormal findings). The above tests are limited to children under two years of age (also limited to two per recipient). For more information, please refer to Appendix A.

Information Concerning PKU Test and Newborns

According to the American Academy of Pediatrics, Guidelines for Health Supervision III, Health Supervision: Newborn Visit, page 19, states, "Screen for phenylketonuria and other disorders (hypothyroidism, hemoglobinopathies, galactosemia) prior to discharge or after 24 hours of age according to state law." A single PKU is adequate when performed at least 24 hours after birth in a well infant or when performed at 6-7 days of age in a premature or ill infant. Repeat PKUs may be performed at the discretion of the physician. Specimens should be sent to the Alabama State Laboratory for processing. Providers obtaining the specimen may bill for the collection (procedure code 36415) using modifier "90".

REMINDER

Outpatient Cardiac Rehab Services

Outpatient cardiac rehab services may be billed for dates of service 12/1/00 and after using revenue code 943 and CPT codes 93797 or 93798. Claims that are within the one-year filing limit may be billed to EDS. Outdated claims should be submitted to Medicaid for administrative review so the filing limit may be waived. Mail these claims to: Georgette Harvest, Customer Service, PO Box 5624, Montgomery, AL 35103.

Medicaid Recommends Oral Exams Every Six Months

A periodic oral examination is recommended once every six months for eligible Medicaid recipients under 21 years of age. Under the EPSDT Program, recipients one year and above must have documentation in their EPSDT records that the recipient is either under the care of a dentist or was referred to the dentist. Please incorporate these guidelines into your EPSDT office protocol.

EPSDT Performed in the Home

A well child check-up (i.e., EPSDT screening) performed in the recipient's home is not a separately reimbursable service when infant assessment or care is being provided through the Maternity Care Program. All care of an infant should be coordinated through the medical home, i.e., Patient 1st provider. If you have questions, please contact Medical Services at (334) 242-5582.

Approval Needed for Hospice or PEC Claims

Hospice or Post Extended Care services must be medically approved by Medicaid prior to payment. Prior to June 1, 2001, the edits for this criteria were not working. Claims paid from 10/01/99 – 05/31/01 without medical approval will be identified and recouped on a future EOP.

No Providing / No Billing

If a provider routinely accepts a Medicaid assignment, he or she may not bill Medicaid or the recipient for a service he or she did not provide, i.e., "no call" or "no show".

Attention: Pharmacy Providers

Enhancements have been made to some interactive pharmacy responses in order to allow the pharmacist to better correct the errors, and reduce the number of calls to the ECS Help Desk. Additional information was added to the response as follows:

2590 - Name Sent = XX Name On File = XX
9070 - License Sent = XXXXXXXX is not on file
A030 - Max Qty = XX.XXX Sent = XX.XXX
1529 - NDC Sent = XXXXXXXXXXXX is not on file

Billing Information for Ambulance Providers

Audit 576 has been corrected so that procedure codes A0428, Basic Life Support, non-emergency transport, and A0382, BLS routine disposable supplies, will be paid on the same date of service. EDS will be identifying and reprocessing line items denied in error.

A Well Child Check-up Reminder

In accordance with the American Academy of Pediatrics, please remember the ages children should be screened (EPSDT) and immunized: 1, 2, 4, 6, 9, 12, 15, 18, and 24 months. Children under two years of age should be screened within two weeks of the periodicity schedule above. Beginning with age 3 children should be screened annually until the individual reaches his/her 21st birthday. Please refer to Appendix A of your Provider Manual for more information.

Lead Toxicity Assessment Provisions

In accordance with Guidelines for Health Supervision III published by the American Academy of Pediatrics, a lead toxicity assessment should be performed on children beginning at 9 months of age through 72 months of age. A blood lead test should be performed on children at ages 12 months and 24 months. Please incorporate this information into your office protocol.

TPL Policy on EPSDT / Preventive Services

Medicaid is a secondary payer to all available third party resources. Providers are not required, however, to file with a patient's insurance first if the service is for EPSDT/Preventive Services (immunizations) unless the patient is enrolled in a managed care plan/HMO or Medicaid pays the provider on an encounter or capitation basis. Medicaid will file with the patient's other coverage for these services if the provider does not do so; however, there may be instances where Medicaid will have to request additional information from the provider for claims submitted with a non-standard CPT code.

Important Information for Eye Care Providers

Medicaid has issued some important information concerning eye care providers. First, when billing for "add power", use procedure code V2199. Second, the Prior Authorization (PA) form is used for multiple requests such as private duty nursing, physical therapy, etc. The certification and recertification blocks are not intended for use by eye care providers but must be completed. Eye Care Providers should check "no" to both of these when completing the PA form. Also, remember to always put "02" (Eyeglasses) in the blank for "PA Type" which indicates the service for glasses, contact lenses, frames, etc. Lastly, do not complete any items regarding ambulance, i.e., "ambulance transport code, ambulance transport reason codes, or patient condition". The ambulance information is located to the right of the first and second diagnosis fields in Section 5 of the PA form. For more information, please refer to Chapter 4, Obtaining Prior Authorization, of your Provider Manual.

Important Mailing Addresses

Pharmacy, Dental, and UB-92 claims	EDS Post Office Box 244033 Montgomery, AL 36124-4033
HCFA-1500	EDS Post Office Box 244034 Montgomery, AL 36124-4034
Inquiries, Provider Enrollment Information, Provider Relations, and Diskettes for Electronic Claims Submission (ECS)	EDS Post Office Box 244035 Montgomery, AL 36124-4035
Medicare Related Claims	EDS Post Office Box 244037 Montgomery, AL 36124-4037
Prior Authorization (to include Medical Records)	EDS Post Office Box 244036 Montgomery, AL 36124-4036
Adjustments / Refunds	EDS Post Office Box 244038 Montgomery, AL 36124-4038

REMINDER

ALL PROVIDERS:

ICD-9 diagnosis codes must be listed to the highest number of digits possible (3,4, or 5 digits). Medicaid has discovered that some diagnosis codes were erroneously loaded to our records. Medicaid will be deleting those codes in the near future. Please verify that the diagnosis codes you use are carried to the furthest subdivision.

Medicaid Coverage Terms for Organ Transplants

Alabama Medicaid will cover organ transplants under the following terms and conditions. These terms will apply to all procedures except corneas:

- Transplants must be performed in the state of Alabama if medically available and appropriate for particular patient and transplant type
- All transplant candidates must be from referrals by EPSDT or the primary physician
- All transplant evaluations must be conducted by the Medicaid primary contractor, University of Alabama Hospital-Birmingham (UAB). If the primary contractor is unable to perform the transplant, a referral by UAB to another facility may be made.
- Prior to referring a transplant recipient to an out-of-state facility or provider, as outlined above, **ALL** transplants have to be evaluated by the appropriate transplant specialist noted in the box to the right:

If you have questions regarding this information, call Alabama Medicaid's Transplant Program at 334-242-5455.

Pediatric Bone Marrow

Dr. Ken Lucas or
Dr. Alan Ship 205-939-9285

Adult Bone Marrow

Dr. Henry Vaughan 205-934-1911

Pancreas/Kidney

Dr. Michael Young 205-975-9200

Liver Transplant

Dr. Steve Bynon 205-934-7714

Heart Transplant

Dr. James Kirklin 205-934-5485

